

BILL TO:

Practitioner: \_\_\_\_\_

P.O.#

O&P Facility: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_

Ship To (if different): \_\_\_\_\_

Shipping Method:

- UPS Ground (No Charge)
- 3 Day Ground
- Blue
- Red
- Red Early

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Patient : \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Age: \_\_\_\_\_ LOM (in degrees): \_\_\_\_\_

Primary Dx: \_\_\_\_\_

Affected Limb's Skin Integrity (circle one) POOR FAIR GOOD

Secondary Dx: \_\_\_\_\_

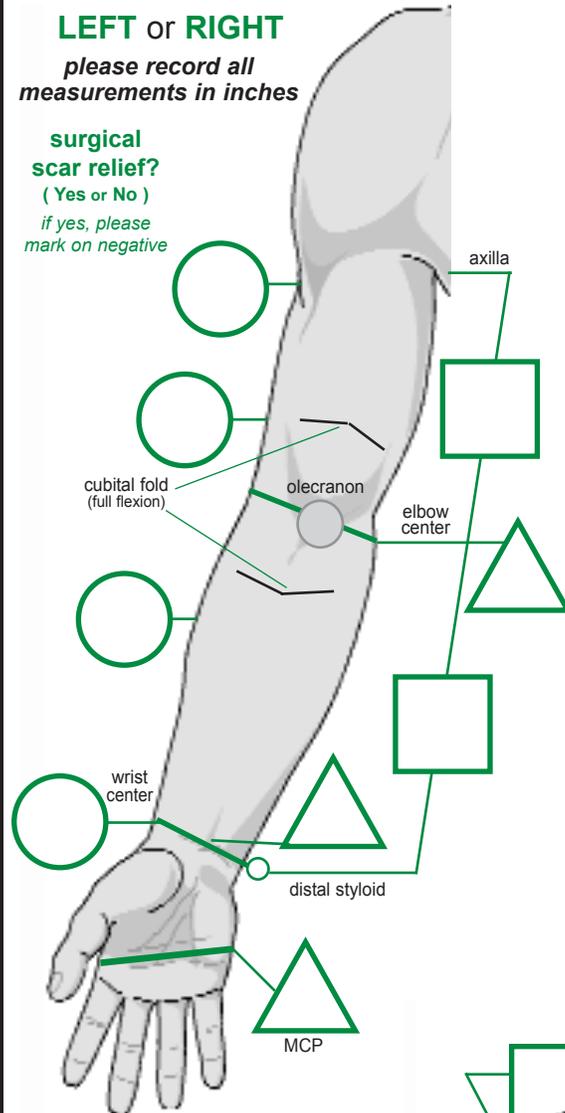
Affected Limb's Circulation (circle one) POOR FAIR GOOD

Affected Limb's Sensation (circle one) POOR FAIR GOOD

**LEFT or RIGHT**

please record all measurements in inches

surgical scar relief? (Yes or No) if yes, please mark on negative



**ATTN:** BEFORE CASTING, PLEASE REVIEW CONSIDERATIONS (located on reverse side)

(M/L)	(R/U)	(MCP)
<b>ELBOW</b>	<b>WRIST</b>	<b>MCP</b>
<b>MEDIAL:</b>	<b>RADIAL:</b>	<b>STATIC CONTROLS:</b> (check all that apply)
<b>TYPE:</b>	<b>TYPE:</b>	<input type="checkbox"/> limit extension
<input type="checkbox"/> pediatric	<input type="checkbox"/> pediatric	<input type="checkbox"/> limit flexion
<input type="checkbox"/> adult	<input type="checkbox"/> adult	<input type="checkbox"/> full lockout
<input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<b>ASSIST NEEDED:</b> (check only one)
<b>STATIC CONTROLS:</b> (check all that apply)	<b>STATIC CONTROLS:</b> (check all that apply)	<input type="checkbox"/> extension assist
<input type="checkbox"/> limit extension	<input type="checkbox"/> limit extension	<input type="checkbox"/> flexion assist
<input type="checkbox"/> limit flexion	<input type="checkbox"/> limit flexion	
<input type="checkbox"/> full lockout	<input type="checkbox"/> full lockout	
<b>ASSIST NEEDED:</b> (check all that apply)	<b>ASSIST NEEDED:</b> (check all that apply)	
<input type="checkbox"/> extension assist	<input type="checkbox"/> extension assist	
<input type="checkbox"/> flexion assist	<input type="checkbox"/> flexion assist	
<b>LATERAL:</b>	<b>ULNAR:</b>	<b>CLOSURES</b>
<b>TYPE:</b>	<b>TYPE:</b>	<b>HUMERAL:</b>
<input type="checkbox"/> pediatric	<input type="checkbox"/> pediatric	<input type="checkbox"/> rigid
<input type="checkbox"/> adult	<input type="checkbox"/> adult	<input type="checkbox"/> flexible
<input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> straps/pads
<b>STATIC CONTROLS:</b> (check all that apply)	<b>STATIC CONTROLS:</b> (check all that apply)	<b>FOREARM:</b>
<input type="checkbox"/> limit extension	<input type="checkbox"/> limit extension	<input type="checkbox"/> rigid
<input type="checkbox"/> limit flexion	<input type="checkbox"/> limit flexion	<input type="checkbox"/> flexible
<input type="checkbox"/> full lockout	<input type="checkbox"/> full lockout	<input type="checkbox"/> straps/pads
<b>ASSIST NEEDED:</b> (check all that apply)	<b>ASSIST NEEDED:</b> (check all that apply)	<b>HAND:</b>
<input type="checkbox"/> extension assist	<input type="checkbox"/> extension assist	<input type="checkbox"/> rigid
<input type="checkbox"/> flexion assist	<input type="checkbox"/> flexion assist	<input type="checkbox"/> flexible
	<input type="checkbox"/> sup/pro assist	<input type="checkbox"/> straps/pads
		<b>HAND TRIMLINES:</b>
		<input type="checkbox"/> full handpiece
		<input type="checkbox"/> MCP trim
		<input type="checkbox"/> other _____
		<b>THUMB ENCLOSURE:</b>
		<input type="checkbox"/> full closed
		<input type="checkbox"/> open
		<input type="checkbox"/> channel
		<input type="checkbox"/> spica

MCP 1   MCP 2   MCP 3   MCP 4

circumference at base

functional hand position

Wrist Center

**LEFT or RIGHT**

Does cast need correction to functional hand position? (Yes or No)

Notes: \_\_\_\_\_

PLASTIC:  Blue HDPE (standard) .140 - .187

HDPE:  Yellow.140  Black.140, .187  Red.140  White.140, .187  Pink.125  Purple.125

POLYPRO .187:

Black  White

STRAPS:

Black  White

FOAM:  1/4" (standard)

1/8"  3/8"

# Casting Considerations for Ultraflex Custom Molded Orthoses

## UPPER EXTREMITY

- 1) Patient evaluation should generally follow ABC “SOAP” procedures - Subjective, Objective, Assessment, & Plan and specifically follow the Ultraflex Manual-Catalog. Note: evaluations & orthoses designs differ for ortho & neuro patients.
- 2) Document all anatomic landmarks & measurements noted on Ultraflex Custom Fabrication Order Form.
- 3) Cast affected limb, maximizing levers inferior & superior to joint, spanning 2/3 to 3/4 of each limb segment. Note areas of open wounds, skin grafts, etc... (that require relief or modification) directly on cast stockinette.
- 4) Introduce gentle hand pressure to extend or flex the limb (as applicable) in the direction of intended correction. For cases requiring both flexion & extension correction, cast in a comfortable mid-range position.
- 5) Place casting tube opposite of where intended shells will provide force (to minimize obscuring anatomy at points of body interface). For example, on a flexion assist KO, place tube on posterior aspect for an anterior shell brace design.

### Typical limb postures for orthopedic indications

#### Orthopedic

##### Elbow

Elbow should be in midrange with wrist neutral in all planes (“handshake”)



##### Wrist

Wrist should be in intrinsic plus position



#### Neurological

##### Elbow-Wrist Flexor/Pronator Spasticity

Forearm to neutral or to full supination to extent feasible



##### Elbow-Wrist FirstFlex™ Orthosis

Wrist in intrinsic plus position,  
drop wrist as necessary



Call Ultraflex Clinical Technical Support at 1-800-220-6670 for any questions.